

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0004259</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Stephenson Nursing Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/99</u> to <u>11/30/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>2945 South Walnut</u> <u>Freeport</u> <u>61032</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Stephenson</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Sherry A. Gravenstein</u> (Title) <u>Administrator</u>	
Telephone Number: <u>815-235-6173</u> Fax # <u>815-235-1309</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Gregory A. Dunham, CPA</u> (Firm Name & Address) <u>Lindgren, Callihan, Van Osdol & Co.</u> <u>328 West Stephenson, Freeport, IL 61032</u> (Telephone) <u>815-233-1512</u> Fax # <u>815-233-1487</u>	
IDPA ID Number: <u>36-6006654</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>01/01/71</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Penny Smith</u> Telephone Number: <u>815-235-6173</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center# 0004259 Report Period Beginning: 12/1/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>44</u>	Skilled (SNF)	<u>44</u>	<u>16,104</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>120</u>	Intermediate (ICF)	<u>120</u>	<u>43,920</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>164</u>	TOTALS	<u>164</u>	<u>60,024</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>62</u>	<u>248</u>		<u>310</u>	8
9	SNF/PED					9
10	ICF	<u>43,167</u>	<u>14,108</u>		<u>57,275</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,229</u>	<u>14,356</u>		<u>57,585</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 95.94%

D. How many bed-hold days during this year were paid by Public Aid?

351 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/1961

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 7 and days of care provided 310Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: n/a Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Stephenson Nursing Center

0004259

Report Period Beginning:

12/1/99

Ending:

11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary		1,394	694,178	695,572	(5,495)	690,077	(1,113)	688,964			1
2	Food Purchase											2
3	Housekeeping	202,153	28,129	2,141	232,423		232,423		232,423			3
4	Laundry	144,607	35,525	861	180,993		180,993		180,993			4
5	Heat and Other Utilities			115,375	115,375		115,375		115,375			5
6	Maintenance	69,751	34,268		104,019		104,019		104,019			6
7	Other (specify):* central supply purch	45,290			45,290		45,290		45,290			7
8	TOTAL General Services	461,801	99,316	812,555	1,373,672	(5,495)	1,368,177	(1,113)	1,367,064			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	2,486,421	156,693	416,761	3,059,875	(1,439)	3,058,436		3,058,436			10
10a	Therapy											10a
11	Activities	95,058	1,905		96,963		96,963		96,963			11
12	Social Services	86,417			86,417		86,417		86,417			12
13	Nurse Aide Training		2,522		2,522	1,139	3,661		3,661			13
14	Program Transportation		1,309		1,309		1,309		1,309			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,667,896	162,429	421,561	3,251,886	(300)	3,251,586		3,251,586			16
	C. General Administration											
17	Administrative	49,504			49,504		49,504	27,224	76,728			17
18	Directors Fees											18
19	Professional Services			9,311	9,311		9,311		9,311			19
20	Dues, Fees, Subscriptions & Promotions			4,665	4,665	300	4,965		4,965			20
21	Clerical & General Office Expenses	95,590	16,229	8,827	120,646		120,646		120,646			21
22	Employee Benefits & Payroll Taxes			306,612	306,612	5,495	312,107	442,497	754,604			22
23	Inservice Training & Education			377	377		377		377			23
24	Travel and Seminar			2,693	2,693		2,693		2,693			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice							44,235	44,235			26
27	Other (specify):* HR Director	34,664			34,664		34,664		34,664			27
28	TOTAL General Administration	179,758	16,229	332,485	528,472	5,795	534,267	513,956	1,048,223			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,309,455	277,974	1,566,601	5,154,030		5,154,030	512,843	5,666,873			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Stephenson Nursing Center

#0004259

Report Period Beginning:

12/1/99

Ending:

11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			114,525	114,525		114,525		114,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* bequests			23,330	23,330		23,330		23,330			36
37	TOTAL Ownership			137,855	137,855		137,855		137,855			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			9,170	9,170		9,170		9,170			39
40	Barber and Beauty Shops		565		565		565		565			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,007	81,007		81,007		81,007			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		565	90,177	90,742		90,742		90,742			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,309,455	278,539	1,794,633	5,382,627		5,382,627	512,843	5,895,470			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning: 12/1/99

Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
1	Day Care			1
2	Other Care for Outpatients			2
3	Governmental Sponsored Special Programs			3
4	Non-Patient Meals	(1,113)	1	4
5	Telephone, TV & Radio in Resident Rooms			5
6	Rented Facility Space			6
7	Sale of Supplies to Non-Patients			7
8	Laundry for Non-Patients			8
9	Non-Straightline Depreciation			9
10	Interest and Other Investment Income			10
11	Discounts, Allowances, Rebates & Refunds			11
12	Non-Working Officer's or Owner's Salary			12
13	Sales Tax			13
14	Non-Care Related Interest			14
15	Non-Care Related Owner's Transactions			15
16	Personal Expenses (Including Transportation)			16
17	Non-Care Related Fees			17
18	Fines and Penalties			18
19	Entertainment			19
20	Contributions			20
21	Owner or Key-Man Insurance			21
22	Special Legal Fees & Legal Retainers			22
23	Malpractice Insurance for Individuals			23
24	Bad Debt			24
25	Fund Raising, Advertising and Promotional			25
26	Income Taxes and Illinois Personal Property Replacement Tax			26
27	Nurse Aide Training for Non-Employees			27
28	Yellow Page Advertising			28
29	Other-Attach Schedule			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,113)	\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	1	2	
	Amount	Reference	
31	Non-Paid Workers-Attach Schedule*		31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization & Pre-Operating Expense		33
33	Adjustments for Related Organization Costs (Schedule VII)	513,956	VII B 34
34	Other- Attach Schedule		35
35	SUBTOTAL (B): (sum of lines 31-35)	\$ 513,956	36
36	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 512,843	37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38			\$		38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line
	Amount	Reference
1	\$	1
2		2
3		3
4		4
5		5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
13		13
14		14
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72		72
73		73
74		74
75		75
76		76
77		77
78		78
79		79
80		80
81		81
82		82
83		83
84		84
85		85
86		86
87		87
88		88
89		89
90 Total	0	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning:

12/1/99

Ending:

11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,113)	0	0	0	0	0	0	0	0	0	0	(1,113)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	27,224	0	0	0	0	0	0	0	0	0	27,224	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	442,497	0	0	0	0	0	0	0	0	0	442,497	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	44,235	0	0	0	0	0	0	0	0	0	44,235	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	513,956	0	0	0	0	0	0	0	0	0	513,956	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,113)	513,956	0	0	0	0	0	0	0	0	0	512,843	29

Summary B

Facility Name & ID Number	Stephenson Nursing Center	#	0004259	Report Period Beginning:	12/1/99	Ending:	11/30/00
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Stephenson Nursing Center# 0004259Report Period Beginning: 12/1/99Ending: 11/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	22	Employee benefits	\$	Stephenson County, Illinois	100.00%	\$ 442,497	\$ 442,497	1
2	V	26	Insurance		Stephenson County, Illinois	100.00%	44,235	44,235	2
3	V	17	County administrator		Stephenson County, Illinois	100.00%	10,013	10,013	3
4	V	17	County treasurer		Stephenson County, Illinois	100.00%	4,305	4,305	4
5	V	17	County clerk		Stephenson County, Illinois	100.00%	5,229	5,229	5
6	V	17	County board		Stephenson County, Illinois	100.00%	6,369	6,369	6
7	V	17	County courthouse		Stephenson County, Illinois	100.00%	1,308	1,308	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 513,956	\$ * 513,956	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center # 0004259 Report Period Beginning: 12/1/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center# 0004259

Report Period Beginning:

12/1/99Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Stephenson Nursing Center**# **0004259** Report Period Beginning: **12/1/99** Ending: **11/30/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	2
3. Under or (over) accrual (line 2 minus line 1).	\$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

	FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet:

54,954

B. General Construction Type:

Exterior

Block & cement

Frame

Number of Stories

1

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing facility	392,040	1853	\$	1
2					2
3	TOTALS	392,040		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98			1971	\$ 613,691	\$ 15,343	40	\$ 15,343		\$ 460,266	4
5	66			1988	1,687,286	42,182	40	42,182		527,277	5
6	alzheimers unit			1993	189,427	4,736	40	4,736		34,334	6
7	garage building			1972	2,912		20			2,912	7
8	building			1984	149,592	3,740	40	3,740		56,976	8
	Improvement Type**										
9	improvements				15,878		10			15,878	9
10	boiler repairs				1,000		15			1,000	10
11	roof repairs				10,634	531	20	531		10,102	11
12	sidewalks				1,276	64	20	64		1,128	12
13	improvements				2,555	102	25	102		1,723	13
14	improvements				3,816	255	15	255		3,333	14
15	improvements				27,483	687	40	687		7,901	15
16	improvements				8,038	803	10	803		6,832	16
17	improvements				1,110		10			1,110	17
18	improvements				8,557	213	10	213		1,301	18
19	improvements				8,991	900	40	900		5,670	19
20	improvements				8,258	206	10	206		1,146	20
21	parking lot expansion				10,659	533	40	533		2,687	21
22	water heater				2,475	248	20	248		1,207	22
23	water heater				3,449	344	10	344		1,624	23
24	fire dampers				744	29	10	29		140	24
25	parking lot expansion				26,914	1,345	25	1,345		5,439	25
26	roof top air/heat units				14,936	1,493	20	1,493		5,228	26
27	smoke detectors				2,248	225	10	225		787	27
28	carpeting & vinyl				3,828	383	10	383		1,340	28
29	roof top air/heat units				14,997	1,499	10	1,499		3,749	29
30	water heater/sprinkler system				17,742	1,774	10	1,774		4,435	30
31	carpeting & vinyl				3,449	345	10	345		862	31
32	blacktopping				6,755		10			6,755	32
33	roof				11,804		10			11,804	33
34	roof				9,092		10			9,092	34
35	roof				4,546		10			4,546	35
36	TOTAL (lines 4 thru 35)				\$ 2,874,142	\$ 77,980		\$ 77,980	\$	\$ 1,198,584	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	tuckpointing			1975	2,700	78	35	78		1,903	9
10	fire doors			1975	4,443	127	35	127		3,120	10
11	plaster			1976	917	26	35	26		633	11
12	alarm system			1976	350	10	35	10		240	12
13	fire alarm			1983	1,360		10			1,360	13
14	alarm system			1990	11,316	566	10	566		11,317	14
15	water softener			1990	9,178	458	10	458		9,178	15
16	dehumidifier			1990	9,500	475	10	475		9,500	16
17	ansul fire door			1999	1,374	137	10	137		206	17
18	roof a/c unit			1999	11,080	1,108	10	1,108		1,662	18
19	paving			2000	7,942	159	25	159		159	19
20	smoke wall			2000	13,973	350	20	350		350	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 74,133	\$ 3,494		\$ 3,494	\$	\$ 39,628	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 231,532	\$ 28,676	\$ 28,676	\$	10	\$ 149,519	37
38	Current Year Purchases	15,932	797	797		10	797	38
39	Fully Depreciated Assets	406,853					406,853	39
40								40
41	TOTALS	\$ 654,317	\$ 29,473	\$ 29,473	\$		\$ 557,169	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	resident use only	Ford bronco	1990	\$ 3,313	\$	\$	\$	5	\$ 3,313	42
43	resident use only	Colt wagon	1989	9,359				5	9,359	43
44	resident use only	Dodge van	1999	35,748	3,575	3,575		5	10,724	44
45										45
46	TOTALS			\$ 48,420	\$ 3,575	\$ 3,575	\$		\$ 23,396	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,651,012	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 114,522	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 114,522	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,818,777	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ _____

13. /2002 \$ _____

14. /2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input checked="" type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	1,262	\$		1,262	
2	Books and Supplies		97			97	
3	Classroom Wages (a)		1,484			1,484	
4	Clinical Wages (b)		698			698	
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests		120			120	
9	TOTALS	\$	3,661	\$		3,661	
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,661				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		\$
	Licensed Speech and Language										
2	Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 146,473	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	494,871		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	113		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 641,457	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	2,948,276		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	702,737		16
17	Accumulated Depreciation (book methods)	(1,818,777)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	15,735		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,847,971	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,489,428	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 142,398	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	219,974		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to other Co. funds	221,848		36
37	Other payables	81,249		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 665,469	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 665,469	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,823,959	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,489,428	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,043,235	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,043,235	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(213,103)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) adjust for compensated absences	(6,173)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (219,276)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,823,959	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Stephenson Nursing Center

0004259

Report Period Beginning: 12/1/99

Ending: 11/30/00

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,739,246	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,739,246	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	14,965	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 14,965	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	1,606	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,601	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,207	23
D. Non-Operating Revenue			
24	Contributions	12,022	24
25	Interest and Other Investment Income***	10,914	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 22,936	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>real estate taxes</u>	388,170	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 388,170	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,169,524	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,373,672	31
32	Health Care	3,251,886	32
33	General Administration	528,472	33
B. Capital Expense			
34	Ownership	137,855	34
C. Ancillary Expense			
35	Special Cost Centers	9,735	35
36	Provider Participation Fee	81,007	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,382,627	40
41	Income before Income Taxes (line 30 minus line 40)**	(213,103)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (213,103)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Stephenson Nursing Center**# **0004259**Report Period Beginning: **12/1/99**Ending: **11/30/00**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,776	2,080	\$ 47,045	\$ 22.62	1
2	Assistant Director of Nursing	1,800	2,080	46,265	22.24	2
3	Registered Nurses	31,004	34,407	600,742	17.46	3
4	Licensed Practical Nurses	21,010	27,202	378,654	13.92	4
5	Nurse Aides & Orderlies	142,825	153,278	1,390,231	9.07	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,712	2,000	30,195	15.10	9
10	Activity Assistants	11,011	12,047	95,058	7.89	10
11	Social Service Workers	5,678	6,360	56,222	8.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	5,831	6,417	69,751	10.87	17
18	Housekeepers	26,963	28,234	202,153	7.16	18
19	Laundry	18,787	20,512	144,607	7.05	19
20	Administrator	1,520	2,080	49,504	23.80	20
21	Assistant Administrator					21
22	Other Administrative	1,840	2,080	34,664	16.67	22
23	Office Manager					23
24	Clerical	10,208	11,000	95,590	8.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,935	2,131	23,484	11.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>central supply</u>	3,551	3,983	45,290	11.37	33
34	TOTAL (lines 1 - 33)	287,451	315,891	\$ 3,309,455 *	\$ 10.48	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 702,334	ln 1 col 3	35
36	Medical Director	12	4,800	ln 9 col3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	2,400	ln 10 col 3	39
40	Physical Therapy Consultant	853	33,554	ln 10 col 3	40
41	Occupational Therapy Consultant	508	18,981	ln 10 col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	74	3,638	ln 10 col 3	43
44	Activity Consultant	19	867	ln 11 col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,478	\$ 766,574		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,049	\$ 35,855	ln 10 col 3	50
51	Licensed Practical Nurses	17,259	318,886	ln 10 col 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	18,308	\$ 354,741		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Sherry Gravenstein	Administrator	0	\$ 49,504
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,504
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Altschuler/Melvoin/Glasser	Medicare report		\$ 5,605
American Express	Medicare invoice		963
Freeport Journal Standard	Legal notice		93
HCFA Lab Cert renewal	CLIA Certification		150
Lindgren, Callihan, Van Osdol	Audit		2,500
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 9,311
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	45,364
Unemployment Compensation Insurance			6,127
FICA Taxes			247,561
Employee Health Insurance			305,726
Employee Meals			5,495
Illinois Municipal Retirement Fund (IMRF)*			143,445
Employee incentive program			886
TOTAL (agree to Schedule V, line 22, col.8)			\$ 754,604
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			2,426
Health Care Worker Background Check (Indicate # of checks performed 25)			300
County NH Assoc			1,640
IL NH Dues			75
Policy manual			175
Admit dues/NIADA dues			70
Personnel Legal Alert			129
UHF Purch			150
Less: Public Relations Expense	(
Non-allowable advertising	(
Yellow page advertising	(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 4,965
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			985
Seminar Expense			1,708
Entertainment Expense	(
(agree to Sch. V, line 24, col. 8)			\$ 2,693

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Stephenson Nursing Center

STATE OF ILLINOIS

0004259

Report Period Beginning:

12/1/99

Ending:

Page 23

11/30/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. County Nursing Home Assoc. \$1,640
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,775 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 81,007
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 5,495 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,151
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Firm Name: Lindgren, Callihan, Van Osdol & co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. County report not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.